United States Court of Appeals

for the Second Circuit

APPELLANT'S BRIEF

ORIGINAL

United States Court of Appeals
SECOND CIRCUIT

8/28

Docket No. 75-7294

NATIONAL LIFE INSURANCE COMPANY,

Plaintiff-Appellee,

against

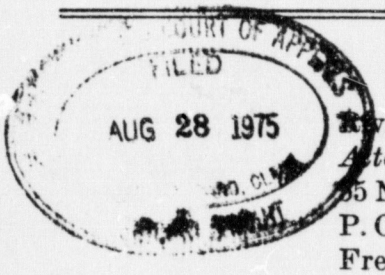
IRENE SOLOMON and LOUIS SCHUSTER as Trustee of the S & L Pension Trust-R.T.B. Industries, Inc.,

Defendants-Appellants.

B P/S

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF NEW YORK

BRIEF ON BEHALF OF DEFENDANTS-APPELLANTS



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Preliminary Statement

The name of the Judge who rendered the decision appealed from is Walter Bruchhaussen.

Statement of the Case

Defendants-appellants Irene Solomon and Louis Schuster, as Trustees of the S & L Pension Trust-R.T.B. Industries, Inc. submit this brief in support of their appeal from

the decision of the Hon. D. J. Buchhausen (United States District Court, Eastern District, New York) entered 3/31/75 wherein summary judgment pursuant to Rule 56, Federal Rules of Civil Procedure was granted in favor of plaintiff-appellee, National Life Insurance Company (hereinafter NLI). The action below was initiated by NLI for rescission of life insurance policy #1462973 which it had issued to Herbert Solomon. NLI successfully contended below that rescission was warranted because of material misrepresentations in the policy application.

On September 8, 1973, Herbert Solomon, the assured, was the victim of a homicide. He had made application to Irving Aronson, an NLI agent, on March 20, 1973, for a life insurance policy in the amount of $240,792.00. The annual premium on the policy was $12,204.11. Thereafter on March 27, 1973, Mr. Solomon was examined by Dr. William J. Godfrey, M.D., and Dr. Nicholas Kuzmowicz, M.D., at the request of NLI. These doctors inserted the alleged responses of Mr. Solomon to a series of interrogatories posed on Part B of the application. The application of Herbert Solomon indicates a negative response to the question of whether he had ever had shortness of breath, pain around the heart, palpitations or any other indication of heart disease, a negative response to the question of whether he had had X-rays of EKG's taken in the past five years, a negative response to the question of whether applicant had consulted a physician during the past five years, and a negative response to the question of whether applicant had ever been hospitalized. It is these responses which plaintiff-appellee claims must irrevocably cancel the policy.

Prior to the issuance of the policy, Mr. Solomon signed and delivered to NLI a Request for Amendment of Application, which reflected his visits to Dr. Karl Friedman, his family physician. Mr. Solomon's amended answer to the question asking whether he consulted a physician in the past five years was affirmative, that he had visited Dr.

Friedman for check-ups and minor complaints from 1961-1972 and that the results of all such examinations were normal.

In April, 1973, at the request of NLI, Dr. Friedman forwarded a description of his treatment of Mr. Solomon on a form provided by NLI. At this time, Dr. Friedman disclosed that on at least two prior occasions, he had cause to examine Mr. Solomon's heart, that he had found it normal, and on at lease one prior occasion he had cause to administer an EKG, and the result of the test was that Mr. Solomon's heart was normal. In fact, Dr. Friedman did not actually disclose to the insurance company all of Mr. Solomon's previous visits to him, but at no time did Dr. Friedman diagnose Mr. Solomon as having any heart disease, nor did any EKG administered by Dr. Friedman show an abnormal condition.

More than one month later, on May 28, 1973, the medical director of NLI reviewed and approved the application of Mr. Solomon and in June, 1973, life insurance policy # 1462937 was issued.

The record below indicates that although the applicant first met with NLI agent Aronson in March, 1973, premium payments were predated to November 30, 1972 and the policy reflects issuance on that date. One day prior to this issuance date, Mr. Solomon was admitted to Doctor's Hospital, Freeport, New York, where he remained for five days. Neither Mr. Solomon nor Dr. Friedman actually disclosed this hospitalization to the insurance company. Nevertheless, all EKG's, blood tests and any and all other tests administered at this time were "normal". In spite of these test results, the hospital physician, Dr. Edward Braverman, a doctor never before consulted by Herbert Solomon, wrote up a discharge diagnosis of "arteriosclerotic heart disease." No other doctor had ever made such a diagnosis on Mr. Solomon, and Dr. Braverman's diagnosis is unsupported by any medical data.

In support of its argument that the charged misrepresentations of Mr. Solomon were material, the insurance company submitted an affidavit of its medical director, Dr. Brian McCracken, to the effect that "had he been aware of Mr. Solomon's medical condition he would have refused to enter the contract." This was the only evidence submitted in support of the contention of materiality, and Dr. McCracken's bald assertion was unsupported by any factual data.

The affidavit of Irene Solomon, wife of the deceased, was submitted by appellant in opposition to the insurance company's motion for summary judgment. Mrs. Solomon stated in the affidavit that NLI's agent, Irving Aronson, knew the full extent of Mr. Solomon's medical history, including the EKG's and the November hospitalization. When questioned by Mr. Solomon in relation to his answers on his application, Mr. Aronson had replied, "Don't worry about it. Forget it".

In granting the insurance company's motion for summary judgment, the District Court in effect held that statements made by the deceased in his application for life insurance were material misrepresentations as a matter of law; that the insurance company had neither actual nor constructive notice of the deceased's complete medical history; and that the insurance company was not charged with whatever knowledge was possessed by its agent, Mr. Aronson, who sold the policy to the deceased.

Appellant contends that the District Court erred in granting plaintiff's motion for summary judgment.

First, appellant does not concede or admit that the decedent, Mr. Solomon, made any misrepresentations on his application for the policy or the amendment thereto.

Second, appellant contends that it was improper for the Court pursuant to a summary judgment motion to hold as a matter of law that all of the alleged misrepresentations

were material. Materiality is not a question to be decided on summary judgment, particularly when plaintiff's evidence consists of a single, unsupported affidavit. The question of materiality may only be decided after evidence is presented at the trial, and only when based on substantial, uncontroverted proof. Considering all of the proof presented by the insurance company, an issue of fact as to the materiality of the alleged misrepresentation exists.

Third, appellant contends that, in order to hold that Mr. Solomon's alleged misrepresentations were material, it is necessary to show that he suffered from the disease which he is charged with concealing. Since there is a genuine issue of fact as to whether he actually suffered from heart disease, summary judgment was improperly granted.

Finally, appellant contends that a genuine issue of fact exists as to whether the insurance company had actual or constructive notice of the deceased's complete medical history. In addition, appellant contends that as a matter of law, the insurance company is charged with the knowledge of Mr. Aronson, its agent, and there is a question of fact as to the extent of Mr. Aronson's knowledge of the deceased's medical history. It should be emphasized that if the insurance company is found to possess such actual or constructive notice, or if Mr. Aronson is found to possess knowledge of the deceased's medical history, then the company will be estopped from rescinding the policy on the basis of the alleged misrepresentations.

POINT I

A genuine issue of fact exists as to whether the alleged misrepresentations of the deceased are material. The Court improperly held them material as a matter of law, because such a holding must be based on substantial, uncontroverted evidence, not a single unsupported affidavit, and the question of materiality should not be decided until after evidence has been presented at trial.

The deceased is charged with having misrepresented that he had never suffered from heart disease, that he had not consulted a doctor within 5 years preceding his application, that he had not had X-rays or EKG's taken within those 5 years, and that he had never been hospitalized.

In order to be a basis for rescinding the insurance contract, these alleged misrepresentations must be material (Subdivision 2, Section 149, Insurance Law). That same section of the Insurance Law defines materiality as follows: "No misrepresentation shall be deemed material unless knowledge by the insurer of the facts misrepresented would have led to a refusal by the insurer to make such contract." In addition, for purposes of determining materiality, subdivision 4 of section 149 provides, in part:

> "A misrepresentation that an applicant for life . . . insurance has not had previous medical treatment, consultation or observation, or has not had previous treatment or care in a hospital or other like institution, shall be deemed . . . a misrepresentation that the applicant has not had the disease, ailment, or other medical impairment for which such treatment or care was given . . .

In granting the insurance company's motion for summary judgment, the District Court held that Mr. Solomon's

alleged misrepresentations were material "as a matter of law", relying on *Fleet Messenger Service* v. *Life Ins. Co. of N. America,* 314 F.2d 593 (2d Cir. 1963). The only evidence considered by the Court was the single affidavit of the medical director of the insurance company, in which he stated that a policy would not have been issued if the deceased's true history and condition were known. This statement was not supported by any factual data such as actuarial tables or evidence of past practices of the insurance company.

Appellant contends that it was improper for the Court to hold that the alleged misrepresentations were material as a matter of law, when the evidence submitted by the insurance company in support of its motion consisted of a single, unsupported affidavit. A court may hold that misrepresentations are material as a matter of law, but only if the decision is based on substantial, uncontroverted evidence, including evidence on the question of whether the insurance company had in the past insured similar risks (see Subdivision 3, Section 149, Insurance Law). In the case at bar, no evidence was considered as to the past practices of the insurance company, and, in the absence of substantial, uncontroverted evidence, the question of materiality is for the jury. *Tierney* v. *Travellers Ins. Co.,* 179 Misc. 604, aff'd 267 AD 804 (Dept. 1943).

Appellant further contends that a court may hold misrepresentations material as a matter of law only after evidence of materiality has been presented at trial, or, at the very earliest, after the beneficiary has been given the opportunity, through discovery, to explore the question of how the insurance company has handled similar risks.

It follows, therefore, that a court should not decide the question of materiality in a motion for summary judgment. Although this has been done, see for example, *Gam* v. *Equitable Life Assurance Soc. of U.S.,* 67 Misc. 2d 724

(Sup. Ct. Bronx County, 1971), the better view is that a decision on materiality should be postponed until evidence is presented at trial, or at least until discovery. In fact, in *Roth* v. *Equitable Life Assurance Soc. of U.S.*, 186 Misc. 612, aff'd 269 AD 746 (1947), the insurance company's motion for summary judgment was denied, the court saying at 186 Misc. 614:

> "The plaintiff (beneficiary) should not be precluded . . . from an opportunity of showing at the trial, through cross examination or otherwise that the misrepresentations on the part of the assured . . . would not have led to a refusal by the insurer to make such contract. Plaintiff may be able through cross examination or otherwise, to show that the practice of the insurer was to accept similar risks. See sub. div. 3, sec. 149 Insurance Law. The facts regarding the defendant's practice with respect to the acceptance or rejection of similar risks are peculiarly within the knowledge of the defendant and outside that of the plaintiff. Under such circumstances, plaintiff should not be denied an opportunity of at least cross examining the defendant's witnesses regarding the latter's practice with respect to the acceptance or rejection of similar risks."

In addition, the case of *Peterson* v. *New England Mutual Life Ins. Co.*, 33 AD 2d 547 (1st Dept. 1969), supports the argument that a decision on the materiality of a misrepresentation should be delayed at least until the beneficiary has the opportunity, through discovery, of examining past insurance company practices. In *Peterson*, an examination before trial was ordered to permit the beneficiary to ascertain the "practice of the insurer with respect to the acceptance or rejection of similar risks." *Id.* at 547. In the case at bar, the appellant was given no discovery, although duly demanded.

The following cases lend additional support to the position of the appellant:

In *Bean* v. *Metropolitan Life Insurance Co.*, 7 Misc. 2d 1044 (Sup. Court Warren County, 1957), the deceased failed to disclose in his application for life insurance a serious ailment and a visit to the doctor for treatment. These misrepresentations are very similar to the misrepresentations allegedly made by Mr. Solomon. In *Bean*, the Court set aside a jury verdict in favor of the beneficiary, and directed a verdict in favor of the insurance company, holding that, pursuant to subdivision 4 of Section 149 of the Insurance Law, the misrepresentations were material as a matter of law. It must be emphasized that the holding that the misrepresentations were material as a matter of law was based on substantial, uncontroverted evidence, including evidence of past insurance company practice, that the company would not have issued the policy if the true facts were disclosed in the application. In addition, judgment was rendered after evidence relevant to an inquiry of materiality had been presented at the trial. Judgment was not entered pursuant to a pre-trial motion for summary judgment.

Likewise, see *Lau* v. *Guardian Life Ins. Co.*, 78 Misc. 2d 332 (Civil Court, New York, 1974). Once again, a verdict was directed in favor of the insurance company, the court holding that the misrepresentations were material as a matter of law, but once again, judgment was based on substantial, uncontroverted proof that the company would not have issued the policy if it had known the deceased's true medical history, and was entered only after evidence was presented at the trial, and not pursuant to a pre-trial motion.

See also *Arcese* v. *Equitable Life Assurance Society*, 32 Misc. 2d 410 (Sup. Ct., Queens County, 1961), and *Ettman* v. *Equitable Life Assurance Society of US*, 6 AD 2d 697 (2nd Dept. 1958).

Finally, in *Fleet Messenger Service* v. *Life Ins. Co. of N. America, supra,* the very case relied upon by the District Court in granting summary judgment, once again the judgment that the misrepresentation was material as a matter of law was based on substantial, uncontroverted evidence, not a single affidavit. It was rendered only after evidence on the issue of materiality was considered at trial, and not pursuant to a motion for summary judgment.

In conclusion, it can be seen that it was an error for the District Court to grant plaintiff's motion for summary judgment. It was error because the judgment was not based on substantial, uncontroverted evidence, and because no evidence of whether the insurance company had accepted or rejected similar risks in the past was considered. Therefore, a question of fact existed as to whether the alleged misrepresentations were material. It was also error because a decision on materiality must wait until the evidence is presented at the trial, and must not be handed down pursuant to a motion for summary judgment.

POINT II

In order to hold that Mr. Solomon's alleged misrepresentations were material, it is necessary to show that he suffered from the disease which he is charged with concealing. Since there is a genuine issue of fact as to whether he actually suffered from heart disease, summary judgment was improperly granted.

Mr. Solomon is charged with making a misrepresentation when he denied ever having had heart disease.

He is also charged with misrepresenting the fact that he had consulted a doctor, taken EKG's, and entered a hospital. According to subdivision 4, section 149 of the Insurance Law, a denial of having undergone treatment for a disease shall be deemed, for purposes of determining materiality, a denial of ever having had the disease.

Thus, for purposes of determining materiality, Mr. Solomon's alleged misrepresentations are denials of ever having had heart disease.

Appellant contends that, in order to find that such misrepresentations are material, it is necessary to establish that Mr. Solomon actually suffered from the disease he supposedly concealed. In *Orenstein* v. *Metropolitan Life Ins. Co.,* 18 AD 2d 1016 (2nd Dept. 1963), the court held that the jury, in determining whether alleged misrepresentations were material had to determine whether the deceased actually suffered from the concealed illness prior to the time he made his application.

Appellant further contends that, since there is a genuine issue of fact as to whether the deceased ever actually suffered from heart disease, it was an error for the District Court to grant summary judgment.

The evidence is far from conclusive that Mr. Solomon ever had heart trouble. No EKG or any other medical test showed an abnormal condition, and the only diagnosis of heart trouble was made by a doctor who had never before treated Mr. Solomon, and was unsupported by any medical data.

A similar situation existed in *Orenstein,* in which the Court characterized the deceased's condition at the time of application as "debatable", and instructed that the jury must pass on the question of whether the deceased ever suffered from heart disease. The court said, at 1016:

> "While the two physicians testified that they formulated no fixed diagnosis that the decedent had any heart impairment supported by objective symptoms. One of them also stated that he had refused to rule out the possibility of coronary insufficiency, and the other admitted that he had made a tentative diagnosis of coronary impairment."

Thus, the question of whether Mr. Solomon ever had heart disease should have been presented to the jury.

The case of *Fleet Messenger Service* v. *Life Ins. Co. of N. America, supra,* relied upon by the District Court in granting summary judgment, must be discussed at this point. Under subdivision 4 of Section 149 of the Insurance Law, according to this decision, "the insured is deemed to have had the disease for which he was treated." *Id.* at 397. Thus, it may be argued that, in determining the materiality of Mr. Solomon's denials of having undergone heart treatment, it is irrelevant as to whether he actually had heart disease. Under 149(4), the argument runs, he is deemed to have had it, and his denial of treatment is a material misrepresentation.

Appellant urges that the Court's reading of 149(4) in *Fleet* is blatantly inaccurate. That provision does not stand for the proposition that the insured is deemed to have had the disease for which he was treated. Rather, it merely stands for the proposition that a denial of treatment is a denial of having had the disease for which treatment was given.

Thus, in determining materiality, it is still necessary to determine whether the deceased actually suffered from the disease.

POINT III

Summary judgment was improperly granted because a genuine issue of fact exists as to whether the insurance company had constructive notice of the deceased's complete medical history. If such notice is found to exist, the company will be estopped from rescinding the policy.

It is well settled that if an insurance company accepts payment of a premium with knowledge of alleged misrepresentations made by the insured, it has waived its right

to rescind the policy. *Bible* v. *John Hancock Mutual Life Ins. Co.*, 256 N.Y. 458 (1931). In other words, the company will be estopped from rescinding on the basis of the charged misrepresentations. This knowledge may be acquired by actual or constructive notice. *Zeldman* v. *Mutual Life Ins. Co. of N.Y.*, 269 App. Div. 53 (1st Dept. 1945).

In granting summary judgment, the District Court relied on the case of *Cherkes* v. *Postal Life Insurance Co.*, 285 App. Div. 514, aff'd 209 N.Y. 967 (1956), and held in effect that no question of fact existed as to whether the insurance company had constructive notice of the deceased's medical history. It is the position of the appellant that such a question of fact does exist.

The first case to be discussed is *Zeldman* v. *Mutual Life Ins. Co. of N.Y., supra.* In *Zeldman,* the Court discussed the problem of constructive notice, saying at 56: "Circumstances putting the insurer on notice may not be deliberately disregarded." The Court continued by saying that if circumstances were such as to require further inquiry, the insurer will be charged with constructive notice of what the inquiry would have revealed.

Appellant argues that there exists a question of fact as to whether the circumstances in the case at bar put the insurance company on notice and required further inquiry.

The circumstances were as follows:

At first, the deceased denied having any heart ailment, or having had any treatment. Then, at the request of the insurer, the deceased signed an amended application, in which were revealed some routine visits to a doctor. Finally, Dr. Friedman, replying to an inquiry by the insurer, revealed information about two such visits, including information indicating that cause existed to examine the deceased's heart. All of this information was received by the insurer before the policy was issued, and before the medical examiner had received the application.

Because the insurance company received its information about Mr. Solomon piece by piece; because each new piece of information contained a little more about Mr. Solomon's treatment; and because each new piece of information was received in response to a request by the insurance company, it is possible to conclude that circumstances had put the insurance company on notice. Certainly, a factual issue exists on this point.

Following Mr. Solomon's death, the insurance company conducted a "routine" investigation and apparently had no difficulty acquiring knowledge of Mr. Solomon's complete medical history. Thus, if circumstances had put the company on notice, it would be charged with this knowledge.

It should be pointed out that in *Zeldman,* the Court held the circumstances therein did not put the insurance company on notice, but that case is distinguishable. In *Zeldman,* the company received information which was supposed to put it on notice only, after the policy had been issued. In the case at bar, the company was put on notice by circumstances prior to issuance of the policy.

The next case to be discussed in *Cherkes* v. *Postal Life Insurance Company, supra.* The Court in *Cherkes* phrased the test as to whether constructive notice exists as follows, at 516: "The question is whether the information given, although partial, was sufficiently indicative of something more to be tantamount to notice of the unrevealed."

In *Cherkes* the Court held that the information revealed did not amount to notice of that unrevealed, but *Cherkes* is distinguishable from the case at bar. In *Cherkes,* the deceased revealed a past gall bladder operation, and this was held not to be indicative of a totally unrelated kidney condition. In the case at bar, the deceased and his physician revealed some information about past treatment, and the necessity of examinations, for heart disease. There is at the very best a factual question as to whether the information revealed about past heart treatment amounts

to notice of the unrevealed related heart treatment, particularly when the circumstances by which the insurance company received its information are recalled.

There is one very important additional piece of evidence in support of the contention that, at the very least, a factual question exists as to whether the insurance company was put on notice. Although the insurance policy was approved in June, 1973, it was predated to November 30, 1972, and this policy reflects issuance on that date. This is significant in that it creates the possibility that the company knew that Mr. Solomon was a high risk, and that it predated the policy so that the first yearly premium, paid on March, 1973 could effectively cover a period during a portion of which there was no risk. Certainly before summary judgment is granted, the beneficiary should be given an opportunity to explore the significance of predating this particular policy.

Finally, in *Columbian National Life Ins. Co.* v. *Rodgers*, 116 F. 2d 705, 707 (10th Cir. 1971), the following statement appears:

> "An insurance company may be charged with knowledge of facts which it ought to have known . . . knowledge which is sufficient to lead a prudent person to inquire about the matter, when it could have been ascertained conveniently, constitutes notice of whatever the inquiry would have disclosed, and be regarded as knowledge of the facts."

Thus, it is quite possible to conclude from an examination of the circumstances of the case that the insurance company had been put on notice as to Mr. Solomon's true medical history, *Zeldman* v. *Mutual Life Insurance Co. of N. Y., supra.* Or, in other words, it is possible to conclude that information reviewed by the insurance company and the manner in which it was received, was indication of what was revealed, *Cherkes* v. *Postal Life Ins. Co.,*

supra. In view of the issue of fact, summary judgment should be reversed and the case remanded so that evidence may be received on this important issue of whether the insurance company is estopped from rescinding the policy.

POINT IV

In this particular situation, where the insurance agent assured the insured that his alleged false answers would not prejudice his rights under the policy, the beneficiary should be allowed to litigate the issue of what knowledge was possessed by the agent, and have this knowledge imputed to the insurance company.

The Court below, in granting plaintiff's motion for summary judgment, rejected appellant's contention that the insurance company, through its agent Mr. Aronson, had knowledge of the deceased's complete medical history and was therefore estopped from rescinding the policy on the basis of the alleged misrepresentations in the applications.

The Court noted the following provision which appeared in Part A of the application, which in turn was affixed to the policy:

> "No statement made to or information acquired by any representative of the company shall bind the company unless set out in writing in Parts A or B of this application."

The Court apparently held that such a provision in a life insurance policy is valid, see, for example, *Axelroad* v. *Metropolitan Life Ins. Co.*, 267 N.Y. 437 (1935), and since the company is not charged with knowledge of communications to its agent unless affixed to the policy, inquiry into the state of the agent's knowledge is "foreclosed". *Gam* v. *Equitable Life Assurance Society of U.S., supra.*

Appellant contends, however, that in spite of the rule of the *Axelroad* case, and in spite of the provisions of Section 142 of the Insurance Law, not relied upon by the District Court, public policy demands that, in certain situations, the insurance company must be charged with the knowledge of its agent.

In support of its argument, appellant relies on the case of *Sternaman* v. *Metropolitan Life Insurance Co.*, 170 N.Y. 13 (1902). In *Sternaman*, the beneficiary sued to recover the proceeds of a life insurance policy. When the company defended on the grounds that material misrepresentations appeared in the application, the beneficiary charged that he gave correct information to an agent of the company, who recorded said information inaccurate, and that therefore the company should be charged with whatever knowledge was possessed by the agent. It was established that the insured had signed a provision limiting the authority of the agent.

The Court in *Sternaman* held that the beneficiary would be allowed to offer proof of the information actually given to the agent, and that the insurance company would be charged with knowledge of that information. Such a holding was necessary, argued the Court, in order to protect the insured from fraud:

> "The company might perpetrate a fraud upon the insured by issuing a policy and accepting premiums thereon, knowing (through its agent) all the time that the contract was void, or voidable at its election . . ." *Id.* at 24.

The *Sternaman* decision has never been overruled, although the Court of Appeals has purportedly undermined its precedential value by its interpretation of Section 142 (formerly Section 58) of the Insurance Law, adapted after the *Sternaman* case, and by its decision in the *Axelroad* case. Section 142 passed for the purpose of protecting the

insured and his estate, provides in effect that every life insurance policy in New York must contain the entire contract, and must be in writing. In *Minsker* v. *John Hancock Mut. Life Ins. Co.*, 254 N.Y. 333 (1930), the Court viewed this statute as prohibiting a beneficiary from introducing evidence of truthful communications made to an agent of the insurance company but not recorded. The Court reasoned that, since an insurance company could no longer rescind a policy on the basis of a misrepresentation unless it appeared in or was affixed to the policy, the insured now had the duty to read the policy to make certain that his statements as recorded therein were truthful.

Then, in the *Axelroad* case, the Court of Appeals affirmed validity of a provision contained in the policy which gave express notice that the company would not be charged with knowledge of the information communicated to the agent but not contained in the policy.

Appellant agrees with the Court of Appeals' interpretation of Section 142 and with its decision in *Axelroad* insofar as the Court would exclude evidence of truthful communications made to a company agent when the agent on his own has inaccurately or incorrectly recorded the truthful responses of the insured. However, in situations such as the case at bar, in which the insured is assured by the agent that his incorrect answers will not prejudice his rights under the policy, appellant urges that *Sternaman* should still be controlling.

That these two situations should be treated differently may be explained as follows:

When the insured gives truthful answers to an insurance agent, he is arguably protected by Section 142, in that he will read the policy, become aware of any inaccurate answers, and have them changed, particularly if a limitation on the authority of the agent similar to the one in the case at bar appears in the policy itself.

If, however, the insured, after informing the agent of the truth, is told "not to worry", that inaccurate answers will not prejudice him, he receives no protection from Section 142. Upon reading the policy, he will see his inaccurate answers and even the limitation on the authority of the agent, but will take no steps because of the agent's authoritative assurances that he should not worry.

The dissenting opinion in the *Axelroad* case, a 4-3 decision, points out the fact that a prospective insured is often at the mercy of unscrupulous or ambitious insurance agents, saying at 452:

> "It was common knowledge that agents of life insurance companies, for the purpose of securing the issuance of policies and thereby their commissions, prepared applications for policies in such a way that they would pass and receive the approval of the home office, regardless of the facts stated to them by applicants.
>
> An insured paid his premiums believing he had a valid policy and the beneficiary was often met by the defense of false statements in the application which avoided the policy. Such was the well-known situation when the *Sternaman* case was decided and the opinion was written with that knowledge in mind."

Although Section 142 now affords the beneficiary some protection against such agents, there are still situations, such as in the case at bar, in which the beneficiary is afforded no remedy unless *Sternaman* decision is adhered to.

Appellant emphasizes that it is urged that the knowledge of the agent should be imputed to the company only in situations in which the agent has encouraged the insured to fill out his application inaccurately. In such a situation, as discussed above, the insured receives no protection

from Section 142 of the Insurance Law, or from the presence in the policy of a clause limiting the authority of the agent.

Thus, because appellant has alleged that the supposed false answers were inserted at the encouragement of the insurance agent, he should not be prohibited from litigating the state of the agent's knowledge and from having this knowledge imputed to the insurance company.

And, since there is a genuine issue of fact as to the issue of the agent's behavior and the state of his knowledge, summary judgment in favor of the insurance company was improperly granted.

CONCLUSION

The Order and Judgment appealed from which granted summary judgment to the plaintiff insurance company, pursuant to Rule 56 of the Federal Rules of Civil Procedure was in error and should be reversed.

Respectfully submitted,

RIVKIN, LEFF & SHERMAN
Attorneys for Defendants-Appellants

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hereby admitted this day
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Attorney for